STATE OF MICHIGAN

COURT OF APPEALS

PETE I. MATA, II and KAREN M. MATA, Plaintiffs/Counterdefendants-Appellees,	UNPUBLISHED March 10, 2005
v	No. 251039 Macomb Circuit Court
STEVEN GREKIN, D.O., STEVEN GREKIN, D.O., P.C. a/k/a, d/b/a WARREN DERMATOLOGY a/k/a, d/b/a DERMATOLOGY INSTITUTE OF MICHIGAN, Defendants/Counterplaintiffs-Appellants.	LC No. 02-004290-CZ

Before: Wilder, P.J., and Sawyer and White, JJ.

PER CURIAM.

Defendants appeal as of right from an order granting them a judgment for $742 and denying their motion for sanctions. We affirm.

Plaintiff Pete Mata's employer, Simplified Employment Services (SES) provided its employees with health benefits. SES was self-insured and contracted with PPOM to provide claims administration services. PPOM contracted with doctors to provide covered services at a reduced rate in exchange for prompt payment. Plaintiffs obtained covered medical services from defendants. Defendants submitted claims to PPOM, which were approved and submitted to SES for payment. SES went bankrupt and failed to pay defendants for the medical services rendered to plaintiffs. Defendants billed plaintiffs for the full cost of the services rendered, rather than for the reduced rates charged to insurers. Plaintiffs commenced this action seeking a declaration that they were not obligated to pay the bill, except for co-pay and deductible amounts, because they obtained services on the basis of their insurance coverage. Defendants counterclaimed for $1,180, the full cost of the services rendered, and both parties sought attorney fees and costs. The circuit court awarded defendants the amount defendants would have received from the insurance carrier, and denied the remainder of the parties' claims.

I

Defendants argue that three contracts – between defendants and plaintiffs, between defendants and PPOM, and between PPOM and SES – clearly entitle defendants to the full cost of the services rendered. We disagree.

We review de novo the interpretation of contracts. *Wilkie v Auto-Owners Ins Co*, 469 Mich 41, 47; 664 NW2d 776 (2003). The contract between defendants and plaintiffs states:

> I understand that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I have read all of the information on BOTH sides of this sheet and have completed the above. I certify this information is true and correct to the best of my knowledge.

The reverse side of the Patient Information form, entitled "About Financial Arrangements," states, "Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract," and that "all charges are your responsibility from the date services are rendered."

The contract between PPOM and SES provides:

> In consideration for the Covered Services provided by the HCPs [health care providers] to Patients, [SES] shall pay, in full, all claims for Covered Services submitted by PPOM on behalf of the HCPs. All such claims shall be paid within seven (7) days of the date of receipt of such claim by [SES] at all times when reasonably possible, but in no event later than twenty-one (21) days from the date of receipt of such claim. Said payment shall be tendered directly to the HCP which provided the Covered services. In the event [SES] fails to pay within said twenty-one (21) day period, PPOM may elect, in its sole discretion, to require [SES] to pay the HCPs usual and customary rates/charges instead of the adjusted amount. . . .

The contract also provides that the HCPs, such as defendant, are third-party beneficiaries of the contract between PPOM and SES.

The contract between defendants as HCPs and PPOM provides:

> 11. PAYMENT FOR HCP SERVICES.
>
> A. HCP shall submit to PPOM all claims for Covered Services within a reasonable time after the provision of such Covered Services. HCP shall submit same on its customary billing form and shall set forth therein it's [sic] usual and customary charges for the Covered Services rendered. However, except as set forth in a subparagraph C hereinbelow, HCP hereby agrees to accept as payment in full for all Covered Services rendered the lesser of:

1. HCP's usual and customary charges for such services; or

2. that amount set forth on the Master Payment Schedules.

HCP shall be entitled to recover from the applicable Insurer for Covered Services which are Medically Necessary and covered under a Patient's Health Plan, the amount determined hereinabove less any co-insurance or deductible specified in such Patient's Health Plan (which amounts HCP may recover from the Patient), and/or less any coordination of benefit reimbursement for which another payor is prior obligated (which amounts HCP may recover from any other obligated third party payor). HCP shall not be entitled to collect any co-insurance or deductible from any Patient until HCP's bill has first been received and adjusted by PPOM as set forth hereinabove. In the event the applicable Insurer fails to pay HCP for Covered Services which are Medically Necessary and covered under a Patient's Health Plan, after obtaining PPOM's written consent, HCP may pursue the Patient (and any person legally responsible for the Patient) for payment. . . .

* * *

C. Except as specifically set forth in this subparagraph C, HCP shall not accept payment, or otherwise be compensated for services rendered, in an amount which exceeds that amount which HCP is entitled to receive as set forth hereinavove. [Further language not applicable here.]

After defendants submitted their usual and customary charges to PPOM, and PPOM adjusted those charges to the lesser amount indicated on its schedules and submitted the claims to SES, and SES failed to pay the claims, PPOM sent a notice to defendants:

October 8, 2001

Re: Simplified Employment Services ("SES")

Dear PPOM Provider:

As you may be aware, SES filed bankruptcy and an "automatic stay" was issued against its creditors that prevents you from collecting payments directly from SES for claims for Covered Services provided to its plan participants. Further, your contract with PPOM prohibits you from pursuing the Patient without PPOM's written consent. Accordingly, to facilitate your collection of your fee, PPOM hereby grants you permission (pursuant to section 11 A.2 of your provider agreement with us) to pursue the patient (and any person legally responsible for the patient) for payment for Covered Services which were Medically Necessary and covered under such Patient's Health Plan (as these terms are defined under your provider agreement) in an amount equal to that which you were entitled to receive from SES.

PPOM, LLC

On November 12, 2002, PPOM sent a letter to SES:

> November 12, 2002
>
> Joseph Whall
> Disbursing Agent
> Simplified Employment Services
> P.O. Box 215710
> Auburn Hills, MI 48321
> Re: Offers of partial payment to PPOM providers
>
> Dear Mr. Whall:
>
> We have received contacts by providers taking exception to the offer of Simplied Employment Services (SES) to make partial payment for services rendered to SES patients after July 9, 2001.
>
> These offers are contrary to the terms of the Employer Plan Administrator Agreement with PPOM which states:
>
> 6. Consideration:
>
> A. In consideration for the Covered Services provided by the HCPs to Patients, EMPLOYER PLAN ADMINISTRATOR shall pay, in full, all claims for Covered Services submitted by PPOM on behalf of the HCPs. All such claims shall be paid within seven (7) days of the date of receipt of such claim by EMPLOYER PLAN ADMINISTRATOR at all times when reasonably possible, but in no event later than twenty-one (21) days from the date of receipt of such claim…. In the event EMPLOYER PLAN ADMINISTRATOR fails to pay within said twenty-one (21) day period, PPOM may elect, in its sole discretion to require EMPLOYER PLAN ADMINISTRATOR to pay the HCP's usual and customary rates/charges instead of the adjusted amount pursuant to paragraph 4 herein.

The offer of a partial payment is also contrary to the statements contained in a letter issued by SES after the declaration of bankruptcy that assured providers that: "…any services you will render or have rendered after July 9, 2001 will be processed and paid under normal operating circumstances." A copy of that letter is enclosed for your convenience.

Be advised pursuant to Section 6.A., that PPOM hereby withdraws the PPOM adjusted amount for all claims for Covered Services rendered after July 9, 2001 submitted to SES by PPOM on behalf of the HCPs that SES has failed to pay pursuant to the terms of the Employer Plan Administrator Agreement. Further, PPOM hereby assigns to all HCPs any rights PPOM has under the Employer Plan Administrator Agreement to pursue payment of any claim for Covered Services rendered after July 9, 2001 of an HCP that SES has failed to pay pursuant to the terms of the Agreement.

Please contact me if you have any questions regarding the above.

Sincerely,

Edward W. Fisher
Legal Counsel

II

Defendants argue that their agreement with plaintiffs and their contract with PPOM allow them to collect the full amount of their charges against plaintiffs. The agreement with plaintiffs provides that regardless of their insurance status, they are ultimately responsible for the balance of their account, and that although defendants will bill the insurance company, all charges are plaintiffs' responsibility. These provisions do not refer to a specific amount, and do not address the question whether the amount for which plaintiffs are responsible is the amount the insurance company agreed to pay, but failed to pay, or the amount defendants would charge a different patient who was not subject to the PPOM contract.

Further, while the contact provisions relied on by defendants, section 11 of the contract between defendants and PPOM, does, indeed, state that in the event the insurer fails to pay for covered services, the HCP may pursue the patient for payment after obtaining PPOM's written consent, it also provides that except for situations not involved here, the HCP "shall not accept payment, or otherwise be compensated for services rendered, in an amount which exceeds that amount which HCP is entitled to receive as set forth hereinabove." This is precisely what the October 8, 2001 notice permitted. Moreover, notwithstanding Lynne Wharton's testimony, relied on by defendants, the contracts clearly provide that PPOM may authorize the HCP to seek the greater amount from SES, upon its failure to timely pay a claim, but nowhere provides that the greater amount can be recovered from the patient. The November 12, 2002 letter is in accord with this interpretation of the contracts.

III

Defendants argue that the circuit court erroneously relied on a nonexistent rule of law in reaching its decision, and that the circuit court erred in denying their motion for reconsideration on that basis. We disagree.

We review a denial of a motion for reconsideration for an abuse of discretion. *Ensink v Mecosta Co General Hospital*, 262 Mich App 518, 540; 687 NW2d 143 (2004). However, we review de novo questions of law. *Fultz v Union-Commerce Associates*, 470 Mich 460, 463; 683 NW2d 587 (2004). To prevail in a motion for reconsideration, "[t]he movant must show that the trial court made a palpable error and that a different disposition would result from correction of the error." *Herald Co, Inc v Tax Tribunal*, 258 Mich App 78, 82; 669 NW2d 862 (2003), citing MCR 2.119(F)(3).

Defendants correctly point out that less than a month after the hearing at which the circuit court granted the judgment, our Supreme Court held "that the rule of reasonable expectations has no application in Michigan, and those cases that recognized this doctrine are to that extent overruled." *Wilkie, supra* at 63. The circuit court's order *dismissed* plaintiffs' "reasonable

expectations" claim, and there was no discussion by the circuit court of plaintiffs' expectations. Rather, it appears that the court considered defendants' negotiated fee schedule indicative of the reasonable value of the services for which defendants should be compensated. We see no palpable error. Furthermore, as discussed, the contracts entitle defendants to the amount awarded irrespective of plaintiffs' expectations. Therefore, even if the circuit court erred, it reached the correct result and should be affirmed. See *Grand Trunk Western RR, Inc v Auto Warehousing Co*, 262 Mich App 345, 354; 686 NW2d 756 (2004).

IV

Defendants next argue that the circuit court lacked subject-matter jurisdiction. Defendants assert that because the amount in controversy was less than $25,000, the district court had exclusive jurisdiction. MCL 600.8301(1). "[A] challenge to subject-matter jurisdiction may be raised at any time, even if raised for the first time on appeal." *Smith v Smith*, 218 Mich App 727, 729-730; 555 NW2d 271 (1996). We review the issue de novo, *Rudolph Steiner School of Ann Arbor v Ann Arbor Charter Twp*, 237 Mich App 721, 730; 605 NW2d 18 (1999), and conclude that the circuit court had jurisdiction to hear the action.

"A court's subject-matter jurisdiction is determined only by reference to the allegations listed in the complaint. If it is apparent from the allegations that the matter alleged is within the class of cases with regard to which the court has the power to act, then subject-matter jurisdiction exists." *Trost v Buckstop Lure Co, Inc*, 249 Mich App 580, 586; 644 NW2d 54 (2002) quoting *Grubb Creek Action Committee v Shiawassee Co Drain Comm'r*, 218 Mich App 665, 668; 554 NW2d 612 (1996). The complaint specifically prays "that this Honorable Court enter a Judgment declaring Plaintiffs are not responsible to Grekin for the SES Amount Due." Although the complaint also requested "attorney fees and all other relief deemed necessary," those matters were ancillary. See *Parkwood Ltd Dividend Housing Ass'n v State Housing Development Authority*, 468 Mich 763, 770-772; 664 NW2d 185 (2003) (observing that where the complaint only asks for a declaration of rights, even if money will likely be involved at some point, the "case involves a complaint for declaratory relief only"). MCL 600.8315 provides, "The district court shall not have jurisdiction in actions for injunctions, divorce or actions which are historically equitable in nature, except as otherwise provided by law." Suits for declaratory judgments are equitable in nature. *Coffee-Rich, Inc v Dep't of Agriculture*, 1 Mich App 225, 228; 135 NW2d 594 (1965). Therefore, the pleadings indicate that the circuit court, as a court of general jurisdiction, had jurisdiction to hear this case involving equitable matters. MCL 600.605.

V

Defendants finally argue that the circuit court erred in denying their motion for sanctions. We disagree. We review a trial court's decision regarding a motion for sanctions for clear error. *Kitchen v Kitchen*, 465 Mich 654, 661; 641 NW2d 245 (2002). "A decision is clearly erroneous where, although there is evidence to support it, the reviewing court is left with a definite and firm conviction that a mistake has been made." *Id*. at 661-662.

Although several of plaintiffs' specific grounds for obtaining relief failed, plaintiffs' underlying argument that they were not obligated to pay more than the contracts entitled

defendants to receive was meritorious. Therefore, defendant has not shown that the circuit court erred in denying sanctions.

Affirmed.

/s/ David H. Sawyer
/s/ Helene N. White